Medication Administration Guidelines

1. A written authorization and order completed and signed by the student's physician and a parent/guardian is required before any medication can be given in school.
2. Medications include:
    - Prescription drugs
    - Over-the-counter drugs
    - Topically applied ointments
    - Eye or ear drops
    - Inhalers
    - Nasal sprays or mists
3. The physician order must be complete, dated and written to cover the entire school year or for a specific length of time as determined by the physician.
4. Medication orders must be renewed annually or if a change in dosage occurs.
5. Parents/guardians are responsible for providing medication and any supplies needed for the school to administer it. **Medication that arrives at school in any form other than the one it was dispensed in by the pharmacy (medication that has been crushed, divided or mixed by the parent/guardian) will not be given.**
6. The school will only administer prescribed medication that arrives at school in a pharmacy bottle labeled correctly with:
    - Name of Student
    - Name of Medication
    - Name of Physician
    - Dated
    - Strength of medication
    - Dosage
    - Route to be given
    - Frequency or time of administration
    - Special instructions for storage or precautions
7. The information on the pharmacy bottle must match the physician's order on the Authorization for Medication Form.
8. Self possessed and administered over the counter medications must be in the original bottle and form in accordance with the Authorization for Medication Form.

Farmington Public Schools

AUTHORIZATION FOR MEDICATION FORM

Dear Parent and Physician,

PLEASE READ THE ATTACHED MEDICATION ADMINISTRATION GUIDELINES ON THE BACK OF THE FORM.

PHYSICIAN PLEASE COMPLETE THE FOLLOWING

Student's Name_____

Name of Medication_____ Dosage_____

Route Given_____ Time_____

Start Date_____ End Date_____

Child's diagnosis and reason for medication:

_____

Adverse reactions or side effects:

_____

Additional Comments:

_____

I certify this child requires such medication be given during school hours and that no alternative schedule is medically available.

Physician Signature_____ **Date**_____

PrintName_____ Phone_____

Address_____

City/State_____ Zip_____

Signature_____ **Date**_____

Parent/Guardian

PLEASE NOTE: ONLY SECONDARY (GRADE 6-12) STUDENTS MAY SELF-ADMINISTER MEDICATION
This student is both capable and responsible for self-administering this medication according to school policy.

☐ No ☐ Yes – Supervised ☐ Yes – Unsupervised **Physician Initials**_____

Student is authorized to carry this medication ☐ No ☐ Yes

Parent/Guardian_____

☐ Please indicate if you have provided additional information as an attachment. As of 2/22/07

FORM HM 4